Harbor Haven
470 Prospect Avenue, Suite 203B
West Orange, New Jersey 07052
Phone# 908-964-5411 Fax# 908-964-0511
E-mail: info@harborhaven.com
www.harborhaven.com

This page to be completed by parent or legal guardian. This entire form is required by State Law or child cannot attend.

Medical Form

Child's Name_____ Birth Date ___/___/____ Age_____ Sex _____
Last First MI

Parent/Guardian #1: Name _____ Home Address _____
Home# _____ Cell# _____ Work# _____
Parent/Guardian #2: Name _____ Home Address (if different) _____
Home# _____ Cell# _____ Work# _____

IN AN EMERGENCY NOTIFY: (Please list contacts that live a reasonable distance from Harbor Haven. Parents/Guardians will always be contacted first.)

Name _____ Name _____
Address _____ Address _____
City & State _____ City & State _____
Relationship _____ Relationship _____
Cell _____ Cell _____
Alternate Phone_____ Alternate Phone_____

Health History: (check-giving approximate dates)

Ear infections _____	Hay Fever _____	Mononucleosis _____	Mumps _____
Rheumatic Fever _____	Poison Ivy _____	Chicken Pox _____	Asthma _____
Convulsions _____	Insect Stings _____	Measles _____	Lyme Disease _____
Diabetes _____	Heart Disease _____	German Measles_____	Hepatitis _____
Seizure Disorder _____	Drug Allergy _____	Food Allergy _____	Other Allergy _____

Please describe any physical. mental or psychological conditions that require medication, treatment or special restrictions or considerations while at camp. _____

_____

Operations or Serious injuries(dates) _____
Chronic or Recurring Illness _____
Seizures (if yes, please detail) _____

_____

Any specific activities to be encouraged? _____
Any specific activities to be restricted? _____

IMPORTANT: *Please notify Harbor Haven if this child is exposed to any communicable diseases during the three weeks prior to starting the program.*

Parent Authorization

Do you give permission for the following over-the-counter medications to be administered if needed, to your child at Harbor Haven. This may include Tylenol, Advil, Other ☐ YES ☐ NO (please list) _____
Do you give permission for Harbor Haven staff to apply sunscreen on your child? ☐ YES ☐ NO

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed Harbor Haven activities, except as noted by me and the examining physician. In the event I cannot be reached in an emergency, I hearby give permission to the physician selected by the Harbor Haven director to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child as named above.

Signature _____ Date _____

Who has legal custody of this child? _____
Do you carry family medical/hospital insurance? No _____ Yes _____
If yes, indicate carrier _____ Policy or Group # _____

(This page to be completed by a licensed physician) This form is required by State Law or child cannot attend.

Medical Examination

Child's Name: _____ DOB _____

Physician's Name: _____

Physician's Address _____

Physician's Phone _____ Physician's Fax: _____

Physician's Email: _____

This examination should be performed within 12 months of arrival at Harbor Haven. Examination for some other purpose with this time is acceptable. Examination is for determining fitness to engage in an active Harbor Haven program.

Date of exam _____

Code: S – Satisfactory
X – Not Satisfactory (explain)
O – Not examined

Hgt: _____ Wt: _____ B.P. _____
Eyes_____
Glasses/Contacts _____
Ears _____
Nose _____
Throat _____
Teeth _____
Heart _____
Lungs _____
Abdomen _____
Hernia _____

Hgb. Test _____ Urinalysis _____
Extremities _____
Posture (spine) _____
Skin _____
Allergy _____
_____
_____
General Appraisal _____
_____
_____
Seizures _____

(for Girls and Women)
Has this person menstruated?_____
If so, is her menstrual history normal?_____
If not, has she been told about it?_____
Special Considerations _____

Recommendation and restrictions while enrolled in Harbor Haven
Special Diet _____

Medication	Reason	Will this medication be taken during the camp day?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Swimming _____
Strenuous Activity _____
Other _____

I have examined the person herein and have reviewed his/her health history. It is my opinion that he/she is able to engage in Harbor Haven activities, except as noted above.

Examining Physician's Signature _____ Date _____

Please return form to:
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This page to be completed by Physician's office or you may attach a copy of immunization record. This form is required by State Law or child cannot attend.

Child Immunization Record

Child's Name: _____ **DOB:** _____

VACCINE	DATE GIVEN
Diptheria, Tetanus, Pertussis (if Td or DT please indicate*)	
LAST DATE OF TETANUS SHOT	
Polio Virus Vaccine	
Pneumococcal Vaccine	
Hepatitis B Vaccine	
Haemophilus B Vaccine	
Varicella (Chicken Pox Vaccine)	
Varicella	
MMR (Measles, Mumps, Rubella)	
MMR	
Other	
1	
2	
3	
4	
5	

* requires medical exemption

Provisional Admission Attached- date granted ❑

Medical Exemption Attached ❑

Religious Exemption Attached ❑